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More Health Systems Leveraging Representation and Warranty Insurance to Support M&A Activity

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Recent years have presented a host of unprecedented challenges for health systems across the country, including large increases in costs for labor and supplies, rising interest rates, tighter credit, difficulty recruiting and retaining providers, and regulatory uncertainty. According to Kaufmann Hall's M&A Quarterly Activity Report: Q3 2023, 39% of the health system transactions announced in Q3 2023 cited these kinds of financial challenges as drivers.

Despite the challenges, health system executives are optimistic heading into 2024 and expect to engage in significant M&A and strategic partnership transactions. According to **VMG's Health Survey of Health System Leader Expectations for 2024**, 59% of executives expect health system financial performance to improve in 2024. With the improved financial performance, 85% expect the same or more M&A activity compared with 2023. Transactions are anticipated to remain hot in all major service lines, including outpatient surgery, behavioral health, post-acute care, imaging, physician services, urgent care, hospital-at-home, and laboratory.

Trends Driving Dealmaking by Hospitals and Health Systems

Healthcare is a dynamic industry with unique characteristics that support dealmaking in the sector. Not only is spending less discretionary, leading to a counter-cyclical and recession resistant industry, the long-term tailwinds underlying healthcare demand include an aging population and an increase in the incidence of chronic diseases. Hospitals and health systems continue to be highly fragmented despite the amount of consolidation that has taken place—especially when compared to payors—supporting strategies designed to achieve geographic and revenue diversification and operational scale efficiencies; ensuring success of value and risk-based based care models; and improving positioning in the negotiation of reimbursement rates. The consolidation of providers to bend the cost curve with better patient care coordination and expand the continuum of care from the clinic to the home has also been supported by this environment. As a result, consolidation activity continues to occur across provider types, from physician practices to ancillary services, home health, hospice, and hospital networks.

There continues to be a shift from traditional fee-for-service revenue models to value and risk-based care models to decrease the cost of patient care, especially with primary and chronic care providers. The Centers for Medicare & Medicaid Services has been pushing healthcare cost containment efforts and shifting patients away from traditional fee-for-services towards these models. As a result, health systems are engaging in significant transactions involving both direct patient care and technological capabilities. Investment in healthcare information technology (HCIT) is now critical to achieve cost efficiencies, coordinate patient care, and maximize revenue. Health systems are investing in technology and data analytics companies to support these goals, driving M&A activity across the HCIT landscape, including operations management, electronic health records, and revenue cycle management.

While the strategic use of representation and warranty insurance (RWI) capital to transfer risk away from buyers is being widely used by healthcare private equity firms and strategic acquirers, adoption by health systems has been slower. The insurance market for deals involving health systems is now deeper and more robust than ever before. Insurer risk appetite to cover unknown breaches of the representations and warranties made in connection with deals in the healthcare space has significantly increased due to the insurers' need to put significant amounts of capital to work, favorable historical claims data, and improved familiarity by underwriters of issues unique to healthcare transactions.

RWI is available for plain vanilla mergers and acquisitions, as well as acquisitions of minority interests, joint ventures, affiliations/membership substitutions (protecting the capital commitment/assumed seller debt), and it provides insurance capital to backstop any seller indemnities for unknown breaches of the representations and warranties made by a seller or other counterparty (depending on deal structure). An acquisition agreement will contain representations and warranties made by the seller about the target company, and such representations and warranties are usually heavily negotiated by the

parties. In an uninsured transaction, the seller generally agrees to place a portion of the purchase price in an escrow account, commonly for 12-18 months, to indemnify the buyer (subject to certain limitations) for breaches of such representations and warranties. RWI provides a compelling alternative whereby a buyer can purchase a RWI policy and have recourse against an insurance company in the event of a breach rather than against the individuals who—in the healthcare context—are likely providing healthcare services on behalf of the buyer, either as an employee or independent contractor. By using RWI, sellers can achieve a clean exit and buyers receive greater levels of protection than via traditional indemnification. In member-substitution and affiliation transactions (where there is no cash purchase price) and other transactions where the seller-side does not commit proceeds to an indemnity escrow, RWI can provide true recourse to buyers for any breaches discovered after closing.

Key Considerations in Healthcare Deals

Buyers of healthcare provider targets face a myriad of unique risks. The healthcare industry is highly regulated because a significant source of revenue for healthcare providers are government payor programs, such as Medicare and Medicaid. For healthcare providers to treat these patients, they must adhere to multiple regulations including compliance with healthcare fraud and abuse laws—such as the False Claims Act and Anti-Kickback Statute—as well as government billing and coding requirements. Whistleblower and *qui tam* actions are also common in the healthcare industry given the government's involvement. Violation of such requirements can subject buyers to treble (3x) damages.

In addition to the above regulatory risks, healthcare providers are exposed to cyber breaches and data privacy risks given the amount of patient data they manage; they must therefore comply with both general data privacy regulations and regulations protecting health information, such as the Health Insurance Portability and Accountability Act (HIPAA). Adding to the risk landscape, independent contractors are very common in the industry, leading to risks related to misclassification and wage and hour matters. Accounting and financial risks vary across revenue models. Risk-based arrangements are more complicated from an accounting standpoint than the standard fee-for-service model.

These unique risks are in addition to the standard risks inherent in any acquisition, such as historical financial performance and accounting, suppliers, tax, litigation, and environmental risks. The confluence of these risks makes healthcare provider transactions more challenging compared to most other industries. Dealmaking in the healthcare space requires successful risk allocation for goals to be achieved post-closing. While comprehensive due diligence can mitigate risks by uncovering known risks, the way in which unknown risks associated with acquisitions are allocated and transferred needs to be considered. Representations and warranties insurance is a common tool used to achieve successful risk transfer of unknown exposures to the insurance markets. Shifting this risk allows parties to successfully negotiate and consummate a transaction while protecting both sellers and buyers against the unknown. Though RWI is no substitute for comprehensive due diligence, it provides an additional layer of protection against unanticipated complications that could materialize later.

While a robust market exists for deals in the healthcare space, carrier interest will depend on several factors, including:

- Type of healthcare provider or service
- Percent of revenue from government payors
- Revenue model
- Size and scope of the operation, and
- Target's healthcare regulatory compliance history and infrastructure.

Specialist providers, such as ophthalmology, gastroenterology, dermatology, cardiology, and other specialty physician practices and ancillary service providers, including urgent care, surgery centers, medical imaging, labs, and physical therapy are more attractive given the focused set of healthcare services and limited set of billing codes. While still insurable, providers with a higher level of regulatory oversight, such as home health and hospice, are more challenging. Hospitals and health system targets fall on the more challenging end of the spectrum given the number of services they provide and the related difficulty in assessing such broad operations. Value and risk-based models are also more challenging given the more unique financial and accounting aspects compared to standard fee-for-service revenue models. Carrier appetite for hospital and health system targets has increased in recent years, to the point where carriers are frequently willing to provide coverage for representations related to regulatory compliance, joint ventures, data privacy, and many others. As a result, Aon has seen a sustained uptick in health system buyers exploring and utilizing RWI.

Conclusion

The underlying industry dynamics continue to support deal-making by hospitals and health systems, and the industry is positively positioned in light of its unique characteristics. A diverse buyer universe, shifting business models, a fragmented industry, and demographic tailwinds are factors underpinning this positive environment. The RWI market has proven resilient and carrier appetite for healthcare deals is expected to continue to increase. As carriers broaden their risk appetite and gain experience and expertise in underwriting healthcare transactions, RWI will continue to serve as a risk shifting and mitigation tool and improve deal outcomes.

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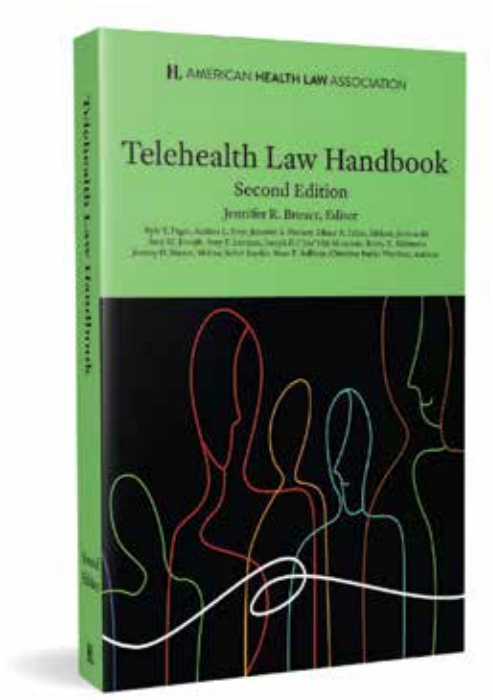

Telehealth Law Handbook

Second Edition

Jennifer R. Breuer, Editor

Kyle Y. Faget, Andrea L. Frey, Jennifer A. Hansen, Elinor A. Hiller, Melania Jankowski, Amy M. Joseph, Amy F. Lerman, Joseph P. McMenamin, Kerry K. Sakimoto, Jeremy D. Sherer, Melissa Sobel Snyder, Sean T. Sullivan, Christine Burke Worthen, Authors

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2024 Market Update: Private Equity and Physician Practice Transactions

John Reiboldt, Managing Director | Coker Group | jreiboldt@cokergroup.com

There has been plenty of discussion of physician practice consolidation by private equity (PE) firms. The market has matured faster than virtually any other, looking more like a tech bubble than an investment in the services space. PE investment went from no interest to hyper interest to heavily consolidated in just over a decade. Many investments have spanned the lifecycle from platform to the proverbial second bite; some are on their third or fourth investor.

While most of these deals have proven wildly successful financially for investors and physician-sellers, a few have struggled. Further, while many of the deals used minimal leverage (e.g., debt) in the early days (having only recently emerged from a massive credit crisis in the financial industry when this trend kicked off in the early 2010s), as valuation expectations increased and access to cheap credit increased, there was some concern around an enormous game of musical chairs: who will be holding the highly leveraged asset when there are no more buyers.

PE Investments in Physician Practices: A Retrospective

PE's involvement in healthcare has changed over the years. The high potential return on investment and lesser risk due to the somewhat recession-proof industry initially drove interest in healthcare. It began in the 1990s by acquiring nursing homes and hospitals and converting them into larger, for-profit businesses. Market consolidation and effective cost controls brought success, thus demanding to go deeper into healthcare. Next, PE invested in many emerging niches, including hospital ancillaries such as anesthesiology and radiology, urgent care, and physician staffing firms. Still, investors were slow to enter the world of clinic-based physician practices. For seasoned investors, the risks were high, and opportunities for return were low: managing physicians and professional services, "stroke of the pen" risk related to high payor concentrations, significant liabilities related to the services, and a range of other factors were all seen as barriers to entry into this market.

Some who took a unique perspective saw an opportunity, and if the risks were appropriately managed, one could capitalize on many positive factors. Factors such as a highly fragmented market, limited platform opportunities, younger partners not wanting to become practice owners, and the need to build critical mass to maximize revenue opportunities while controlling costs were all considered indicators for consolidation.

The idea was familiar, however. It had been undertaken with little long-term success in the late 1980s and 1990s with the growth of physician practice management companies (PPMCs). Despite having a similar investment thesis, the practice of how these were put together caused virtually all of them to crash and burn. Most of these were not backed by PE (a relatively nascent concept then) but had gone to the more traditional public equity market. Vast amounts of wealth were lost when these investments failed.

By the mid-2000s, however, the concept of PE had grown. The number of investors investing in alternative investments like PE flourished, and the PE firms needed a place to invest.

To create a market, you must have buyers and sellers. While most physicians cringe at the thought of working for someone else, most also agree that practicing medicine is not what it used to be. There are more regulations, continued revenue pressures, and rising expenses. Because of this, fewer and fewer people are going into medicine, and those pursuing medical careers lack the entrepreneurial spirit of the last generation.

However, where some see challenges, others see opportunities. Several more business-minded physician group leaders saw this opportunity; they realized there was one thing that the physician practice needed more of and could never access: capital. Thus, there was an opportunity to partner with PE investors who could bring the model proven in other industries to medical practices. The downsides to doing a deal were formidable. Most physician groups did not retain earnings, and thus, they had no excess cash flow on which to capitalize. This standard measurement is earnings before interest, taxes, depreciation, amortization, or EBITDA. The only way to generate EBITDA was for physicians to give up part of their compensation. Some tax benefits are related to capitalizing a portion of compensation, but delivering and understanding that message does not always go together.

Other factors complicate these transactions, like the corporate practice of medicine, physicians' general lack of trust in outside investors, and others. For those who could effectively navigate these issues, the opportunity was real: physician partners had the chance to create, in some cases, significant personal net worth, diversify their risk

exposure, and gain a partner to help promote growth. It wasn't always a win-win, but it was more often than not.

This is not to say there has not been any consolidation in the provider space. Hospital-based specialties have been a target for investors for many years. In the mid-2000s, some of the largest publicly traded companies were provider organizations. Specialties like hospitalists, emergency care, urgent care, and anesthesiology had been undergoing consolidation for many years, but the idea hadn't caught on in the clinic space. 2011 is the year things kicked off--and the growth caught on like a prairie fire. It started with dermatology; within 18 months, eye care was everyone's darling, and interventional pain management was also hot. Then came gastroenterology (GI), orthopedics, otolaryngology (ENT), women's health, urology, etc.

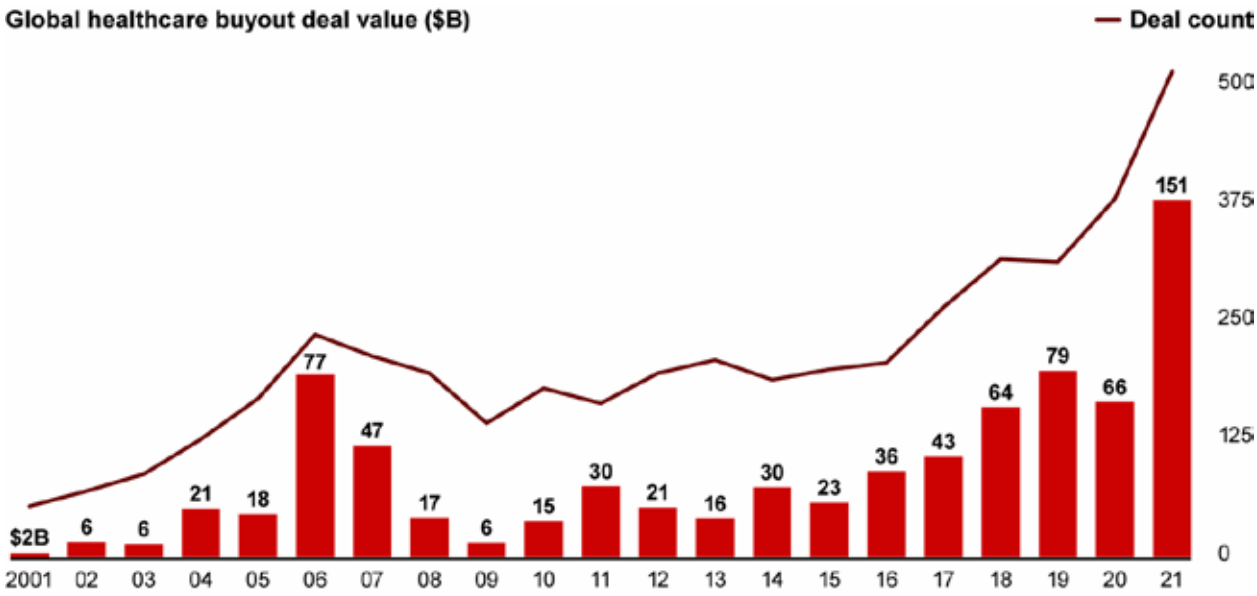
The fascinating aspect was how rapid the growth in consolidation occurred. In 2010, the number of PE firms invested in healthcare was relatively small, and no PE funds *only* focused on healthcare. Today, most large PE firms have a significant amount of their capital devoted to healthcare services, and some only invest in this space. The onslaught of new funds and growing investment in established funds became a self-fulfilling prophecy and juiced an already fast-growing space into one ready to go to the moon.

COVID–19 and the Post–COVID Market

Healthcare has always been viewed as a recession-proof market. In 2008, healthcare had done pretty well, as it always had in market downturns. But it does not matter how recession-proof you are if your doctor's office is shut down, and the first few months of 2020 led many to believe that even healthcare could not stand up to a worldwide pandemic.

Healthcare is fundamentally rooted in pain, specifically treating your pain. No one wants to deal with pain. No one wants to forego lifesaving cancer treatment. If you have a broken bone, you want it fixed. If you have a polyp, you want it diagnosed. Consequently, healthcare was one of the first "businesses" to open (notwithstanding the critical care being given directly related to the pandemic), with many doctors' offices opening for both emergent and elective surgery before other businesses. Healthcare was not only recession-proof, it was pandemic-proof. This led more and more investors to the space, and with a need to put money to work, investments in the physician space skyrocketed.

Of course, deals went on hold during the early stages of COVID-19, and most deal volume in 2020 closed before the pandemic began in the first quarter. But there was so much pent-up desire to invest money and the realization by many physician-partners of what could happen if their business went away that 2021 proved to be a breakout year. Deal volumes increased in number and size, and 2021 set a record for both.



Notes: Dollar numbers are rounded; excludes spin-offs, add-ons, loan-to-own transactions, and acquisitions of bankrupt assets; numbers based on announcement data; includes announced deals that are completed or pending, with data subject to change; deal value doesn't account for deals with undisclosed values; total buyout deal values updated based on Dealogic 2021 sponsor classifications
Sources: Dealogic; AVCJ; Bain analysis

To call 2021 a record year is a little misleading. The volume should be spread over 18 months, given the pause that occurred in 2020. Regardless of how you spread it, 2020 was huge. Buyers, both initial investors and companies already owned by PE (called PE-backed strategics), went on a buying spree. And while many physicians were committed to doing a deal, fewer sellers than buyers still existed. The market has to balance somehow; in this case, the balancing effect came through valuations.

When the market really started moving in the early 2010s, valuations were trading for an EBITDA multiple (a very crude way of measuring transactions, but generally speaking, the most often-used measurement tool) in the high single digits to low double digits, generally between 8.0 – 10.0x. A valuation in this range was considered very attractive. By the early 2020s, valuations were routinely in the 15.0 – 17.0x range, and numbers exceeding 20.0x were not unheard of.

A Maturing Market

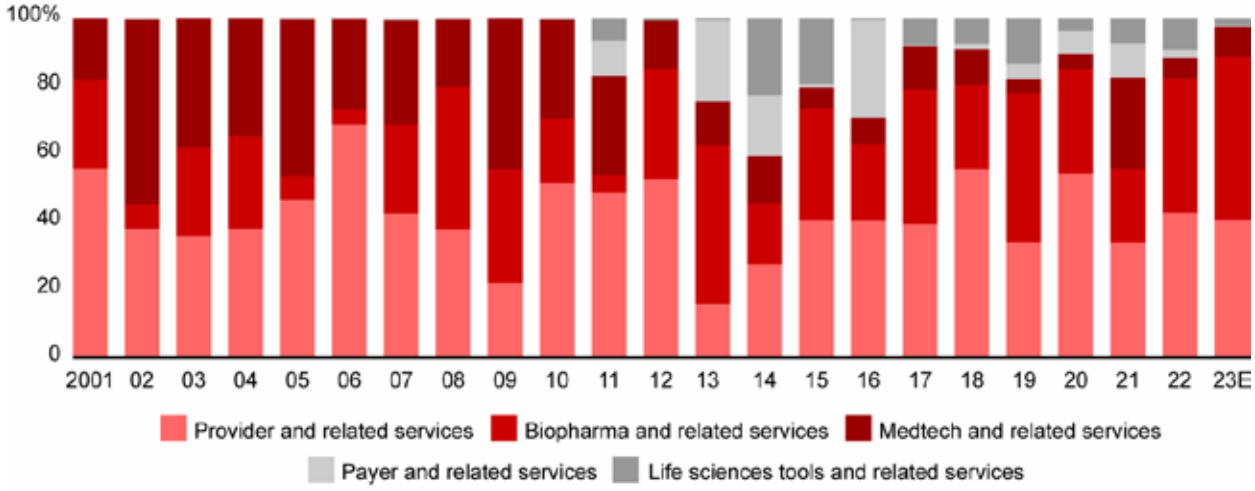
The trend continued into 2022 with it being another banner year for physician practice M&A. While the early days were mainly focused on PE firms creating new platforms by making initial investments into large physician groups (i.e., the platform investment) and then growing by acquiring other groups (i.e., bolt-on investments), the market had matured. Much of the M&A growth was fueled by trading those platforms to other, usually larger, PE firms. This is the *second bite* transaction that we often hear about. By this time, many of these initial platforms have been through their second bite and are even on their third or fourth investor. The market had matured.

The good news is that significant wealth has been created for many investors and physicians. Most of the original physician partners for the platforms are now employees and do not have any ownership in the practice. The practice looks materially different than it did five or ten years ago. It may have undergone one or even a couple of name changes.

Many cautioned the merging of healthcare and business, citing the risk to patient care, but besides a few bad actors, patients continue to receive the level of care they did pre-investment. No investor has ever told a physician how to deliver care.

The chart below shows the deal value and types of entities acquired by PE.

Percentage of global healthcare buyout deal value (excluding add-on deals)



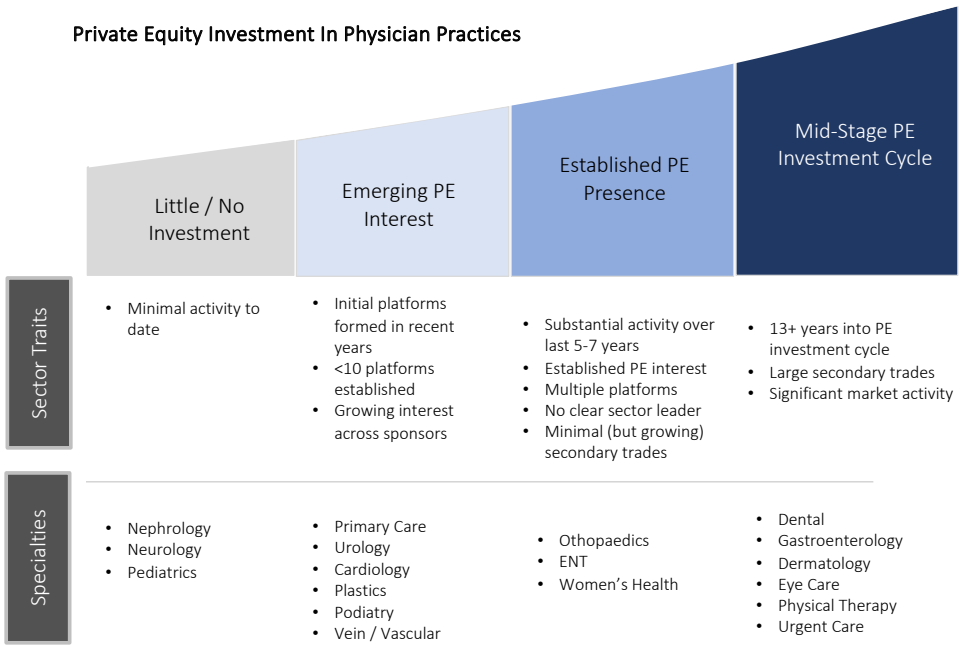
Notes: Excludes spin-offs, add-ons, loan-to-own transactions, special purpose acquisitions, and acquisitions of bankrupt assets; based on announcement date; includes announced deals that are completed or pending, with data subject to change; deal value does not account for deals with undisclosed values; values updated based on Dealogic 2020 sponsor classifications; values include net debt where relevant; 2023E annualized assuming the average ratio of January–November to December from 2019 to 2022, based on data through November 30, 2023; 2010 value includes $1 billion of uncategorized deals
Sources: Dealogic; AVCJ; Bain analysis

Established PE Interest

The original platforms primarily comprised GI, dermatology, and eye care. While some sizeable practices in these spaces never traded and are firmly committed to being private, for the most part, most of the large physician practices have completed transactions. The market is highly consolidated at the large practice level (which differs by specialty).

In dermatology alone, there are over 30 PE-backed groups. GI is closer to half of that, but most of the large GI groups in the nation have consolidated. The market remains fragmented despite the high level of consolidation at the large group level; however, significant opportunities still exist for consolidators to add smaller groups. This will allow PE firms to continue to deploy the significant capital they have raised over the past few years.

Spectrum of Physician Services and Private Equity Investments



Emerging PE Interest: Growth Opportunities

Cardiology

Like other specialties attracting PE interest, cardiology boasts significant tailwinds due to an aging population, technological advancements, and regulatory changes to catheterization (cath) labs and ambulatory surgery centers (ASCs). As the population ages, the need for cardiology services increases due to the prevalence of numerous chronic cardiovascular diseases. Heart disease remains the leading cause of death and is exacerbated by the multiple comorbidities of older patients.

PE investment in cardiology practices will be interesting to watch. Due to fairly significant reimbursement cuts in the mid- to late 2000s related to the specialty's largest ancillary services, cardiac cath labs, many cardiology groups fled to hospitals. They became employed or entered professional service agreements (PSAs). While many large platforms exist, they are not as numerous as other specialties. We have seen several PE investments in the space, including Summit Partners' investment in US Health Partners and Ares Management's investment in US Heart & Vascular. Still, given the total addressable market for the number of inorganic opportunities, the number of platform investments is limited.

Orthopedics

Orthopedics has always been attractive to investors due to several favorable market forces. These include the large breadth of ancillary services that orthopedics offers, the shift to outpatient surgical centers, and growing demand from an aging population.

The loosening regulatory requirements allow private practices to perform more procedures in an ASC environment than ever. Additionally, these procedures are well reimbursed as the Centers for Medicare and Medicaid Services (CMS) seeks to incentivize faster expansion of outpatient care. Finally, the sheer breadth of orthopedic ancillary offerings promises the potential for high returns. Physical therapy, imaging, durable medical equipment, sports medicine, and pain management are only a sampling of the different revenue streams from which a sophisticated orthopedics group can benefit.

Over the past few years, there have been huge transactions with large groups in the orthopedics space. More notable deals include Revelstoke Capital Partners' investment in Beacon Orthopaedics to form OrthoAlliance, and Welsh, Carson, Anderson & Stowe's investment in Resurgens Orthopaedics to form United Musculoskeletal Partners.

Orthopedics looks to continue its position of enviable attention from PE. Moreover, a full service line of musculoskeletal specialties can often be assembled. This bodes well for the physicians and other providers within the service line and the PE firm.

Primary Care

Primary care does not fit the traditional PE model of high compensation, robust ancillaries, and limited hospital interest. It is generally the polar opposite of these characteristics. Primary care is one of the lower-paid specialties; there is little to no ancillary revenue, and hospital ownership and employment are high, given the gatekeeper standing many PCPs maintain. However, there has been a significant change in the PCP market that has driven both public and private investor interest: risk-based medicine. Specifically, this is caused by the aging population and the reliance on the Medicare Advantage (MA) space.

Not only has this proven to be a significant growth area, but some of the largest and most notable investments in healthcare have happened in this space. Risk-based medicine can be profitable for organizations that do it correctly, but this requires large MA populations and adequately managed patients. Some are huge proponents of this model of care, saying that it provides a holistic view of treatment, while others say that it incentivizes just the opposite, i.e., limiting care to manage expenses. Regardless of your view regarding care delivery, the economics, again, if done correctly, can be very significant.

Over the past few years, we have seen some substantial transactions in the space, including Cano Health, Inc.'s SPAC merger in 2021 for $4.4 billion, Amazon, Inc.'s acquisition of One Medical in 2022 for $4 billion, and CVS's acquisition of Oak Street Health for $10.6 billion in 2023. These were PE-owned before their acquisitions, and unfortunately, many have not performed very well. For example, in early February 2024, Cano Health filed for Chapter 11 bankruptcy, and there have been reports of troubles at some of the other large companies focused on risk-based medicine, so it will be interesting to see how this market plays out.

Future of PE in Healthcare

PE is fundamentally reshaping U.S. healthcare. That cannot be argued. Most firms have deep pockets, a keen eye for opportunity, and an extensive history of building successful businesses. PE capital, innovation, and operational excellence may help make healthcare a more effective ecosystem. Investors, physicians, and patients will benefit from the collaborative, forward-looking partnerships between PE and physician practices. Numerous investments and entities have already begun building an improved healthcare system and profiting from their successes. Due to significant market tailwinds, PE involvement is expected to increase further, and the number of patients these developments impact will climb. With this relatively new, dynamic player involved, health systems and hospitals will remain vital. They may still affiliate and partner with physicians and PE. However, it will require new thinking and adjustments from their typical mindsets. Physician employment, for example, may be replaced by contractual arrangements that allow full affiliation with hospitals and a PE firm simultaneously. Time will tell exactly how such relationships will unfold.

PE will maintain its opportunistic approach to achieve financial success. Market forces, regulatory pressures, and technological innovations will direct future PE engagements. They will continue pursuing fragmented specialties and work to bring much-needed consolidation. The savvier PE firms and their practices will learn to

be inclusive of all providers, especially hospitals. Historically, hospitals have viewed PE as a negative, seeing them more as competitors. This perspective will likely change over the next few years. There is a significant opportunity for hospitals and PE-backed physician groups to collaborate and create considerable value for all involved.

Physician Value

Physician partnerships are paramount to PE's success in healthcare, but the physician owners also stand to gain considerably. Historically, physicians would spend 30 years building a practice with a steady base of patients, only to retire without reaping the full benefits of their hard work. A trusted medical practice with a reliable patient population carries tremendous intrinsic value. PE provides physician owners with a large cash payment for the value the physicians created. Of all the affiliation options physicians currently have, PE also pays the most upfront, making them an excellent partner for physicians nearing retirement or needing help with succession planning. Furthermore, since PE funds the expensive technology purchases and ASC buildouts, physicians can enjoy the new opportunities they provide without taking on debt. The value physicians gain from PE partnerships extends beyond the financial benefits. Working as part of a larger group lessens the administrative and call burdens while providing fulfilling participation in a collaborative community. A larger patient population allows physicians to focus on value initiatives, enabling them to pursue bundled and value-based payments. Providers can focus on medicine and giving patients the best possible care instead of relying on antiquated fee-for-service payment models. Finally, and most importantly, physicians who partner with PE groups can help direct the future of healthcare. A thriving healthcare ecosystem *must* have physician leadership so that patient needs and quality clinical outcomes are given the full attention they deserve.

Patient Perspective

Patients also benefit from innovative PE and physician practice partnerships. Traditionally, healthcare was a local business heavily intertwined with the community. As the world grows more connected, patients can access medical services from regional, national, or even global providers. While this brings tremendous opportunity, the patient-provider relationship must be preserved. Physician-PE partnerships that place patient care at the forefront of their business models represent a vital iteration in healthcare. Specifically, patients benefit from the value pursuits that consolidated physician practices undertake. Extra diligence is given to care for patients since value payments increase based on the health and clinical outcomes of the patients. Aligning financial incentives with patient outcomes creates a win-win scenario for everyone involved. Furthermore, ASC procedures have increased quality and better post-op care. As CMS allows more ASCs to perform a broader array of procedures, the number of patients positively impacted will grow. Finally, ASCs provide unmatched patient experience due to the flexible scheduling options. Patients can schedule procedures when it suits them, and receive high-quality treatment and world-class care, all without paying for expensive hospital markups. With the right partnerships and investments, the future of healthcare for patients is bright.

Challenges

When PE started investing in medical practices nearly 15 years ago, many cautioned the merging of healthcare and business, maintaining that profits would win over quality patient care. While you can always find one or two stories where this has been the case, it has not proven pervasive. Healthcare delivery has always been inefficient, but bringing best practices from business, organizational, and process development has helped to make it more efficient. There is nothing wrong with running a practice like a business.

Partnership with PE brings unique challenges for the physician partners. Younger physicians may not be interested in PE ownership due to the reduced compensation and shorter-term focus. Since their compensation haircut is permanent, physicians who stay in practice for a lengthy time after the initial sale are financially better off remaining in private practice. Additionally, agreements involving rollover equity may entail less cash upfront. Further, physicians may not appreciate the loss of autonomy and control. Private practice emboldens physicians with the freedom to practice medicine how they wish, but a partnership with PE means ceding operational control to the new owners. Further, ownership will likely change again due to a subsequent sale of the practice. It is common for PE firms to seek a return on their investment within 3-5 years and move to the next opportunity. Physicians should carefully deliberate before selling to PE as they will lose much control of the practice and cannot revert to the prior structure. For the right physician and practice, partnering with PE can be a lucrative, meaningful way to influence your community and improve patient care.

One matter that could have significant negative effects on PE-backed physician platforms over the coming years is the significant levels of debt they have incurred and how this will play out in a high-interest rate environment. In the early days of these investments, PE used only limited debt levels to fund its acquisitions. The debt level is often expressed as a multiple of EBITDA, similar to valuations. Early in the investment cycle, debt levels were generally in the 2.0 – 3.0x levels, and in some cases, buyers used no debt.

Generally, most people think of debt from a negative perspective, but from a business perspective, prudent debt levels are good. Using debt to fund an acquisition can benefit both the buyer and seller. Using debt to fund specific growth measures is preferable to putting up one's cash. Again, this is only the case when *prudent* debt levels are used.

As valuations that were being paid for initial investments and larger bolt-on transactions increased significantly, especially in the last two

years, investors sought higher returns, and the access to cheap debt burgeoned; many of the second and third-bite investments were funded with significant levels of debt, reaching 6.0, 7.0, and in some cases, 8.0x EBITDA. That is a staggering level of debt and leaves little room for any operating or economic error. Or, as fate would have it, any significant increases in the cost of debt. This is precisely what has happened. Since the financial crisis of 2007-2008, we have been operating in an extraordinarily low-interest rate environment, with the key Federal Funds rate operating somewhere around 0.25%. However, since March 2022, the Federal Reserve has increased its target interest rate by approximately 525 basis points, or 5.25%. When many debt instruments are variable, this leads to a massive price increase in the cost to service this debt.

In cases where these deals were priced very thinly, there was little room for anything negative to occur: no significant reductions in reimbursement or cost increases. If either of these happened, then it would be virtually impossible to meet debt covenants. Many of these platforms that used excessive debt to fund buyouts have seen massive increases in the cost of debt.

While there have been a few major headline collapses, several PE-backed investments are struggling mightily. Indeed, not all of these companies are highly leveraged, but those that are may not survive in this high-rate environment. It will be very interesting to see what happens over the coming months.

Because of this, the M&A environment has slowed significantly, with only a handful of deals completed in 2023. Many are looking to 2024 to be a better year for deals, but deal volume around election cycles can be slow. Those entities that are not highly leveraged will continue to make smaller acquisitions and use their PE fund's cash to fund the investments. And at some point, they will ride out the M&A downturn until it picks back up, as it always does!

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Antitrust Enforcers Walking the Talk: Healthcare Remains Under the Microscope

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As part of the Biden Administration's whole-of-government approach to address perceived consolidation in a variety of industries, including in the healthcare industry, the Federal Trade Commission (FTC) and U.S. Department of Justice Antitrust Division (DOJ) (collectively, the Agencies) are continuing to make good on their promise to increase scrutiny of mergers and acquisitions, along with other conduct they contend is anticompetitive such as labor market restrictions.[1] State attorneys general (AGs) are also taking action, including under newly enacted state healthcare notification laws. The bottom line is that antitrust enforcers are using all of the tools at their disposal to carry out the Biden Administration's mandate and the result is an evolving legal landscape for the healthcare industry.

Navigating Uncertainty Under New Antitrust Rules

The revised Merger Guidelines in December 2023 (Merger Guidelines) were announced by the Agencies just weeks after the FTC issued newly proposed rules under the Hart-Scott-Rodino Antitrust Improvements Act of 1976 (Proposed HSR Rules).[2] The Merger Guidelines represent a significant departure from the 2010 Horizontal and Vertical Merger Guidelines, and the Proposed HSR Rules represent the first time the HSR process has been substantively updated in over 40 years. If implemented in their current form, both will have the effect of making the merger review process lengthier, more complicated, and more burdensome.

In particular, the Merger Guidelines and Proposed HSR Rules will impact healthcare providers in the following ways:

- **Market concentration thresholds for M&A are lower.**
  - An entity or organization with over 30% market share in a relevant service line may be presumed to be in violation of Section 7 of the Clayton Act under certain circumstances.
- **M&A may violate the law when it entrenches or extends a dominant position.**
  - The Agencies will examine whether one party already has a dominant position that the merger may reinforce and will review whether the merger may extend that dominant position to substantially lessen competition or tend to create a monopoly in a different market.
- **When a merger is part of a series of acquisitions, the Agencies may examine all of them.**
  - If an individual transaction is part of a firm's pattern or strategy of multiple acquisitions, the Agencies consider the cumulative effect of the pattern or strategy.
- **Labor market effects will be scrutinized.**
  - The Agencies and AGs have been requesting labor market information as part of their merger investigations.
  - The Proposed HSR Rules will require submission of labor market data as part of any HSR filing, and Guideline 10 in the Merger Guidelines outlines the Agencies' analysis of potential labor market effects.
- **Increased focus on vertical and cross-market theories of harm.**
  - In particular, Guidelines 5 and 6 (and others) could impact healthcare providers that are looking to partner with or acquire a payor, medical device, pharmaceutical company, or other company that provides non-clinical healthcare-related services not offered by the healthcare provider.
  - Vertical mergers or acquisitions will not be allowed to substantially lessen competition by giving a company control over a product, service, or customers that its competitors use to compete or by raising a rival's costs of, excluding or limiting a rival's access to, a related product/service.
  - Cross-market theories of harm will likely be evaluated under a combination of the Guidelines, including Guidelines 5 and 6.

- **Proposed HSR Rules expand the filing parties' disclosure requirements, including:**
  - Areas of actual or potential competition, vertical supply relationships, and strategic rationale for the transaction.
  - Detailed information about the post-transaction structure, the parties' organization, including more information about minority interest holders.
  - Disclosure of both parties' acquisitions going back 10 years where there is horizontal overlap.
  - More expansive disclosure of HSR Item 4(c) and 4(d) documents, including those of supervising deal team leaders and drafts.
  - Disclosure of foreign entity or government subsidies.
  - Disclosure of labor market data.

FTC Reviews Hospital System, Provider Deals Under New Merger Guidelines

Even before the Merger Guidelines were finalized in December 2023, the FTC has been applying them to proposed mergers and acquisitions involving health systems and provider groups, including the following:

- ***FTC and Rhode Island v. LifeSpan and Care New England* – Labor Market Concerns.** The Rhode Island AG, in denying approval of the proposed merger of Lifespan and Care New England in 2022, stated that the combined system would employ 67 percent of the full-time registered nurses employed by the state's hospitals.3 Two of FTC's Commissioners stated that they would have supported a complaint on this basis.4
- ***FTC v. Amgen and Horizon Therapeutics* – Entrenchment of Dominance.** The FTC applied the Merger Guideline regarding dominance in its investigation and challenge to Amgen Inc.'s (Amgen's) acquisition of Horizon Therapeutics plc (Horizon). In May 2023, the FTC filed an injunction seeking to block Amgen's acquisition of Horizon.[5] The FTC alleged that the acquisition would allow Amgen to use its best-selling pharmaceuticals as leverage to pressure insurance companies and pharmaceutical benefit managers into favoring Horizon's two monopoly products or disadvantaging rivals. At the time the suit was filed, the FTC stated that it won't hesitate to challenge mergers that "enable pharmaceutical conglomerates to entrench their monopolies . . ." In September, the FTC and several state AGs announced that Amgen and Horizon entered into a settlement with various conditions that would allow the acquisition to move forward, including that it must receive prior approval from the FTC prior to an acquisition of products that treat thyroid eye disease and chronic refractory gout.[6]

While the FTC (along with DOJ and AGs) are using the more expansive Merger Guidelines to review transactions under new theories of harm such as labor market effects, dominance, and serial acquisitions, it also continues to investigate and challenge transactions under the more traditional theory of horizontal overlap. These include:

- ***FTC v. Novant Health, et al.*** In January 2024, the FTC sued to block Novant Health's acquisition of two North Carolina hospitals. The FTC alleged that the proposed transaction would give Novant control of close to 65 percent of the market for inpatient general acute care services in the Eastern Lake Norman Area of North Carolina.[7]
- ***FTC and California v. John Muir Health, et al.*** In November 2023, the FTC sued to block John Muir Health's proposed acquisition of San Ramon Regional Medical Center in California.[8] The complaint alleged that the transaction would eliminate head-to-head competition between the parties for inpatient general acute care services in the I-680 corridor. The parties subsequently abandoned the transaction.

State AG Investigations Increase Under New Notification Laws

In the last few years, a number of states have enacted comprehensive pre-closing state health care transaction notification laws. This number has grown substantially in the last few years, along with states' concerns about consolidation in local and regional health care markets. Illinois, Minnesota, New York, and California have joined other states (such as Massachusetts and Rhode Island) to require some form of healthcare transaction pre-closing notice and/or approval. Other states such as Pennsylvania and Indiana have proposed notification legislation. Organizations or companies contemplating transactions with health systems, physician practice groups, or other health care entities in these states should take note of the new laws given that the consequences of noncompliance may be substantial, including the potential for fines and the need to delay closing.

Unlike the Agencies, some states can unilaterally block or impose conditions on a transaction without going to court. The California AG used its authority to approve nonprofit hospital transactions, including by imposing conditions on several hospital mergers in recent years.[9] These conditions can be quite significant, including limitations on hospitals' contracts with payors, capping commercial rates, and capping increases—these conditions can be imposed without judicial review. By contrast, the FTC needs to go to court unless the parties will agree to a remedy.

State notification laws are increasing in number and will likely result in AGs reviewing healthcare transactions that have a negligible impact on competition since the laws have a broader scope. In states that have implemented notification laws, healthcare entities should factor additional time and the potential for an AG investigation into their growth strategy.

DOJ Continues to Prosecute Labor Market Restrictions

Since the issuance of the Agencies' 2016 HR Antitrust Guidance,[10] DOJ has repeatedly stated that it views naked wage-fixing and no-poach agreements between competitors as criminal violations of the Sherman Act. While DOJ has not yet persuaded a jury to find any defendants guilty of an alleged criminal no-poach agreement, the fact that the executives from these companies were criminally

indicted signals that companies considering entering into any type of labor market restriction, including a mutual non-solicitation or no-poach agreement, should continue to exercise caution. In order to reduce their risk of a potential criminal prosecution, organizations should document the business rationale for such an agreement, assess whether it is "reasonably necessary" to achieve the goals of a larger business collaboration or arrangement between the parties, and ensure its scope is reasonable in terms of covered employees and length of time.

At the end of 2020, DOJ's first criminal prosecution was announced and others closely followed—all but one of them have involved organizations in the healthcare industry. The indictments and outcomes are summarized below.

- ***U.S. v. Jindal.*** In December 2020, a criminal indictment against Neeraj Jindal was returned by a federal grand jury alleging a per se illegal conspiracy for wage-fixing involving a Texas-based physical therapist staffing company.[11] The criminal indictment alleged that the defendant (Jindal) agreed with a competing staffing agency to reduce the rates paid by each company for physical therapists during a five-month period in 2017. Jindal was also alleged to have separately reached out to four other competing agencies about collectively decreasing rates and was accused of obstructing the FTC investigation.
  - **Outcome:** In April 2022, the jury acquitted both defendants of anticompetitive conduct, but convicted one defendant of obstructing the DOJ's investigation, resulting in a sentence of probation.
- ***U.S. v. DaVita.*** In January 2021, DOJ brought criminal charges against Colorado-based DaVita Inc. (DaVita) and its former CEO, alleging that DaVita and its competitors entered into and engaged in a conspiracy not to poach and hire one another's senior-level employees.[12] The alleged agreement included phone and email conversations between HR professionals, instructions not to solicit certain senior-level employees, and monitoring employees to ensure their adherence to the agreement. The senior-level employees were also required to notify their respective employers that they were seeking new employment in order for their application to be considered by the other companies participating in the arrangement.
  - **Outcome:** In April 2022, after a nearly two-week trial, the jury acquitted all defendants on all charges. A follow-on class action suit against SCA, DaVita and others (*In re Outpatient Med. Ctr. Emp. Antitrust Litigation*) is proceeding before an Illinois federal district court.
- ***United States v. Surgical Care Affiliates LLC.*** In January 2021, DOJ indicted SCA, an operator of outpatient surgical facilities around the country, for an alleged seven-year conspiracy among competitors not to solicit each other's senior-level employees.
  - **Outcome:** In November 2023, DOJ voluntarily dismissed the indictment, a companion case to *DaVita*, without further explanation.[13]
- ***U.S. v. VDA OC LLC and Hee.*** In March 2021, another grand jury returned an indictment against a Nevada-based healthcare staffing company, VDA OC LLC (VDA) and a former manager of the company, alleging they had entered into and engaged in an agreement with a competitor to allocate employee nurses and fix their wages in violation of the Sherman Act.[14]
  - **Outcome:** VDA plead guilty and was sentenced to pay a criminal fine and restitution.[15] In January 2023, Mr. Hee entered into a pretrial diversion agreement with DOJ, committing to performing 180 hours of community service while holding a job, surrendering his passport, and avoiding additional legal troubles in order to avoid jail time.
- ***U.S. v. Manahe.*** In January 2022, four individuals in the home healthcare industry were indicted for alleged agreement to fix wages of personal support workers and not hire each other's employees during the pandemic.[16]
  - **Outcome:** In March 2023, after a two-week trial, the jury acquitted all defendants on all charges.
- ***U.S. v. Lopez.*** In March 2023, DOJ indicted a health care staffing executive alleging he conspired with others to fix the wages of Las Vegas nurses at home health agencies.[17]
  - **Outcome:** Case is pending.

What This Means for You

The Agencies' continued scrutiny of healthcare deals, along with their implementation of the new Merger Guidelines and the revised HSR rules necessitates additional evaluation, planning, and resources when it comes to your organization's growth strategy. The revised HSR Rules and more complex Merger Guidelines, in addition to the burgeoning number of state healthcare notification laws, will increase deal timelines, the merging parties' burden (expense and manpower), and overall uncertainty and potential risk as to the outcome. Deal teams should carefully consider issues like risk shifting, clearance strategy, the appetite for merger challenge litigation, possible remedies, and settlement options at the beginning of a proposed transaction.

Despite its losses, DOJ continues to focus on investigating and prosecuting allegedly illegal restrictions on the labor market. We expect that 2024 will bring more enforcement actions by DOJ for alleged antitrust violations relating to the labor market. Because this area of the law is evolving, we recommend that companies review current HR practices (including participation in salary benchmarking and wage surveys), provide antitrust training for relevant management and employees, and commit to a robust compliance program that accounts for the evolving legal and regulatory landscape.

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